



Health For All

HELPING PEOPLE FIND HEALTHCARE

Children's/Teens Medical Application

Healthy Teens Project - Apple Health For Kids

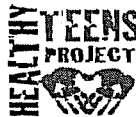
To speed up the application be sure check off and provide the following:

- Signed and dated Application. Answer all questions, using N/A if not applicable.
- Include **PROOF OF INCOME** for the most recent 30 days such as pay stubs etc. If you are self employed, your last year's tax forms (including all schedules) may be used as proof of income. Contact Health For All for if alternative forms of income proof is needed.
- Include **SOCIAL SECURITY NUMBERS** for all family members requesting coverage.
DO NOT put in a false or made-up one.
- IMPORTANT** - Keep a copy of entire application packet for your records and date when mailed to State.

The Application includes a pre-filled DSHS Consent portion so that *Health For All & Healthy Teens Project* can be your Authorized Representative to contact DSHS (with your permission) to assist with the application process.

If you have any questions, *call Healthy Teens Project or Health For All (HFA)*
1-855-487-7686 or locally 444-3066 or
Call the Apple Health For Kids Hotline 1-877-543-7669

As your authorized representative and DSHS contractors, you may send your application to us to check for completeness and keep a copy for future reference:



Health For All
Community-Minded Enterprises
25 W Main Ave Suite 310
Spokane, WA 99201

*Health For All is a project of Community-Minded Enterprises with support from Inland Imaging,
Empire Health Foundation, Providence Health.*

The "Healthy Teens Project" is funded by a federal grant from the Centers for Medicare and Medicaid Services. HTP provides clients services in conjunction with the U.S. Department of Health and Human Services. HTP is not employed by DSHS, but contract to provide application assistance. CFDA #93.767.

Award # IZOCMS330841-01-00

Income Eligibility Guidelines

Family size	THESE INCOME LEVELS QUALIFY FOR: Free health insurance (including non-federally qualified children)		THESE INCOME LEVELS QUALIFY FOR: \$ 20 monthly premium per child. No family pays more than \$40.		THESE INCOME LEVELS QUALIFY FOR: \$ 30 monthly premium per child. No family pays more than \$60.		FOR NON-FEDERALLY QUALIFIED CHILDREN THESE INCOME LEVELS QUALIFY FOR: \$98 monthly premium per child. No family pays more than \$196.	
	Monthly income	Annual income	Monthly income	Annual income	Monthly income	Annual income	Monthly income	Annual income
1	Up to \$1,815	Up to \$21,780	Up to \$2,269	Up to \$27,228	Up to \$2,723	Up to \$32,676	Up to \$2,723	Up to \$32,676
2	Up to \$2,452	Up to \$29,424	Up to \$3,065	Up to \$36,780	Up to \$3,678	Up to \$44,136	Up to \$3,678	Up to \$44,136
3	Up to \$3,089	Up to \$37,068	Up to \$3,861	Up to \$46,332	Up to \$4,633	Up to \$55,596	Up to \$4,633	Up to \$55,596
4	Up to \$3,725	Up to \$44,700	Up to \$4,657	Up to \$55,884	Up to \$5,588	Up to \$67,056	Up to \$5,588	Up to \$67,056
5	Up to \$4,362	Up to \$52,344	Up to \$5,453	Up to \$65,436	Up to \$6,543	Up to \$78,516	Up to \$6,543	Up to \$78,516
6 or more	Add \$637 for each additional child	Add \$7,644 for each additional child	Add \$796 for each additional child	Add \$9,552 for each additional child	Add \$955 for each additional child	Add \$11,460 for each additional child	Add \$955 for each additional child	Add \$11,460 for each additional child

Remember:

- Premiums are based on the number of children in a family but no family pays more than two premiums a month.
- Children must be under the age of 19.
- Pregnancy counts as an additional person.

Application for Apple Health for Kids Benefits



This application is for medical coverage only for children and teens under 19. If you have questions or would like help filling out this form, just call 1-877-543-7669. We'll be happy to help you! Mail completed application to MEDS, PO Box 45531, Olympia, WA 98504-5531.

(List parent, guardian or contact person who will receive follow-up information).

1. FIRST NAME		MIDDLE INITIAL	LAST NAME		
2. ADDRESS WHERE YOU LIVE		STREET	CITY	STATE	ZIP CODE
3. MAILING ADDRESS (IF DIFFERENT)			CITY	STATE	ZIP CODE
4. HOME TELEPHONE NUMBER () ()	WORK TELEPHONE NUMBER () ()	MESSAGE TELEPHONE NUMBER () ()	E-MAIL ADDRESS		
5. Is everyone applying for benefits a Washington State Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list who is not a resident					
6. Do you have trouble speaking, reading or writing English and need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No What language or alternative format do you need?					
7. Do you need help paying for unpaid medical bills within the last 3 months for any of the children you are applying for? <input type="checkbox"/> Yes <input type="checkbox"/> No					
8. Is anyone in your home pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", who?					Due Date:

General Information

9. List family members **living together**. (If needed, attach a separate sheet of paper to list more family members).

NAME (FIRST, MIDDLE, LAST)	SEX M/F	RELATION TO YOU	BIRTH DATE (MO/DA/YR)	OPTIONAL FOR NON-APPLICANTS				
				SOCIAL SECURITY NUMBER	CHECK IF DOCU- MENTED ALIEN	CHECK IF U.S. CITIZEN	RACE *(SEE SAMPLES BELOW)	TRIBE NAME (For American Indians, Alaskan Natives)
A. Parent, Guardian or Self					<input type="checkbox"/>	<input type="checkbox"/>		
B. Spouse or Other Parent (If living in the home)					<input type="checkbox"/>	<input type="checkbox"/>		
C. List Children & Teens Under 19 Years of Age (who want medical benefits)					<input type="checkbox"/>	<input type="checkbox"/>		
D.					<input type="checkbox"/>	<input type="checkbox"/>		
E.					<input type="checkbox"/>	<input type="checkbox"/>		
F.					<input type="checkbox"/>	<input type="checkbox"/>		
G. List Any Adult/Child in the Home who does not want medical benefits.								

* Race and Ethnic background information is voluntary. Race examples: White, Black or African American, Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native or any combination of races. This information will not be used in considering your eligibility for benefits.

Expenses This information can help your children qualify. Do you pay the following expenses?

10. Do you pay for childcare or adult dependent care while you work or court ordered child support for a child who is not living in your home? Yes No
If "Yes", how much per month? \$ _____ For who? _____



Income Enter GROSS pay (before taxes or expenses).		(Please attach proof of recent income)	
11. PARENT'S EMPLOYER NAME		TELEPHONE NUMBER ()	START DATE
12. Amount you received monthly before taxes and expenses are taken out: \$			
13. SPOUSE'S (OR OTHER PARENT LIVING IN THE HOME) EMPLOYER NAME		TELEPHONE NUMBER ()	START DATE
14. Amount your spouse (or other parent living in the home) received monthly before taxes and expenses were taken out: \$			
* If self-employed, you may verify income and expenses with your most recent tax return, including all schedules and attachments if it represents current/projected income.			
Other Household Income	Average Amount Received Monthly	Which Family Member Earns This Income?	Other Household Income
15. Child Support/Alimony	\$		16. Social Security Payment
17. Unemployment Benefits	\$		18. Veterans Benefits
19. Labor & Industries	\$		20. Investment Income Interest/Dividends
21. Other (Please Explain):			\$
Health Insurance Information Tell us about any health insurance your children already have.			
22A. Do any of the children you are applying for already have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	22B. If "Yes", does that health insurance cover doctor, hospital, x-ray (radiology) and laboratory services? <input type="checkbox"/> Yes <input type="checkbox"/> No	23A. Have your children been covered by job-related health insurance in the last 4 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	23B. If "Yes", list monthly amount of premium for children: \$
24. If you checked "Yes" to any of the above questions (22 A or B or 23 A or B), please list the name of the insurance company or employer providing health insurance for your children.			
INSURANCE COMPANY OR EMPLOYER	POLICY NUMBER	POLICY HOLDER'S NAME	POLICY HOLDER'S SOCIAL SECURITY NUMBER (OPTIONAL)
Optional Authorized Representative (Someone you allow the department to talk with about your benefits/receive letters).			
If you would like to name a representative select one option below and complete representative information.			
<input type="checkbox"/> Talk with the department about your benefits; receive no letters. <input checked="" type="checkbox"/> Talk to the department about your benefits and receive letters.			
NAME/ORGANIZATION Health For ALL			TELEPHONE NUMBER 509-444-3066
MAILING ADDRESS 25 W. Main Ave Suite 310		CITY Spokane	STATE WA
			ZIP CODE 99201
Read Carefully Before Signing			
This application is for medical benefits for children only. If anyone in your family already receives, or would like to apply for cash benefits, basic food or other benefits, please contact your local DSHS Community Services Office (CSO).			
<ul style="list-style-type: none"> • DSHS may ask you to prove the information you are giving them to tell if you are eligible. You can ask DSHS for help in getting proof. • Your information may be reviewed by other state or federal agencies. This information will NOT be shared with Immigration and Naturalization Services (INS). • By asking for and getting health care benefits, you give the state of Washington all rights to any medical support and to any third party payments for health care. • DSHS may share your child's immunization history with the Child Profile Immunization Tracking System. 			
DECLARATION AND SIGNATURE			
I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.			
SIGNATURE OF APPLICANT			DATE